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F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff interviews, the facility failed to accurately code	F 278	F278 – ASSESSMENT ACCURACY/COORDINATION/CERTIFIE	9/1/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/30/2017

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F 278	Continued From page 1 the Minimum Data Set in the areas of diagnosis (Resident #95) and behaviors (Resident #73) for 2 of 18 residents. Findings included: 1. Resident #95 was admitted to the facility on 2/13/15. A review of Resident #95 ' s physician's orders dated 5/31/17 revealed Resident #95 had an order for dialysis and vital signs Monday, Wednesday, and Friday and for nursing to assess the shunt site for thrill and bruit every shift. The quarterly Minimum Data Set (MDS) dated 6/22/17 revealed the resident was severely cognitively impaired. The resident required extensive assistance for transfer and bed mobility, total dependence for bathing and dressing, and set up for meals. The diagnoses were hypertension, diabetes mellitus, hemiparesis, seizure disorder, depression, and anxiety. Resident #95 ' s care plan dated 6/22/17 included interventions and goals for chronic kidney disease (CKD) which required a vascular shunt and hemodialysis three times a week. A review of Resident #95's physician progress note dated 7/2/17 revealed the resident ' s diagnoses were CKD stage 5 and end stage renal disease. On 8/15/17 at 11:50 am an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that Resident #95's quarterly MDS dated 6/22/17, Section I, was missing the diagnosis chronic kidney disease stage 5, and	F 278	D Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. Section (I) of the MDS assessment dated for Assessment Reference Date 6/22/17 for Resident #95 was corrected to reflect a diagnosis of Chronic Kidney Disease and resubmitted on August 18, 2017 by the MDS Coordinator. Section (E) of the MDS assessment dated for Assessment Reference Date 7/1/17 for Resident #73 was corrected to reflect behaviors as documented in the 6/29/2017 nursing documentation by the Social Worker. The assessment was resubmitted on August 18, 2017. The Interdisciplinary Team, including the Social Worker and MDS Coordinator were in-serviced by the Corporate MDS Consultant on August 24, 2017 regarding accuracy of assessments. An audit was initiated by the Corporate MDS Consultant on August 18, 2017 to ensure assessment accuracy of all sections. Members of the Interdisciplinary Team assisted in the audit following re-education on August 24, 2017. All	

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F 278	Continued From page 2 this was an error. The MDS should have reflected the diagnosis. On 8/17/17 at 11:30 am an interview was conducted with the Director of Nursing (DON). The DON stated that she expected the MDS Coordinator to accurately code and record all information into the MDS. 2. Resident #73 was admitted to the facility on 10/9/14 and readmitted on 3/25/17 with diagnoses that included respiratory failure, congestive heart failure, and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) assessment dated 7/1/17 indicated Resident #73's cognition was severely impaired. Section E, the Behavior Section, indicated Resident #73 had no rejection of care during the seven day MDS look back period (6/25/17 through 7/1/17). Section E was completed by the Social Worker (SW) on 6/27/17. A review of the medical record for the time period of the seven day look back of the 7/1/17 quarterly MDS (6/25/17 through 7/1/17) for Resident #73 revealed the following: - A nursing note dated 6/29/17 at 2:44 AM revealed Resident #73 refused all medications as well as his insulin. - The June 2017 Medication Administration Record (MAR) for Resident #73 verified the information in the 6/29/17 nursing note. An interview was conducted with the SW on 8/16/17 at 11:35 AM. She stated she was	F 278	active residents' last assessment was audited for assessment accuracy between August 18, 2017 and September 1, 2017. In order to provide Quality Assurance, the Interdisciplinary Team will complete a peer review for assessment accuracy on one assessment per week for three months, and one per month for an additional three months. Results of the peer review audit will be presented to the QAPI committee for a minimum of three consecutive meetings.	

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F 278	Continued From page 3 responsible for completing Section E, the Behavior Section, of the MDS assessments. Section E of the 7/1/17 quarterly MDS for Resident #73 that indicated he had no rejection of care during seven day look back period (6/25/17 through 7/1/17) was reviewed with the SW. The nursing notes and MAR for Resident #73 that indicated he had refused medications during the MDS look back period was reviewed with the SW. The SW revealed she had completed Section E of Resident #73's 7/1/17 MDS on 6/27/17. She indicated the refusals of medications occurred after she had completed Section E of Resident #73's 7/1/17 MDS. She reported she had been trying to complete her required sections of the MDS assessment prior to the Assessment Reference Date (ARD) so the assessments were not completed late. The SW indicated this assessment was coded inaccurately for rejection of care. A follow up interview was conducted with the SW on 8/16/17 at 12:23 PM. She stated she had conferred with the Regional MDS Nurse and she was instructed to wait until after the ARD to complete Section E so she was able to review the entire seven day look back period. An interview was conducted with the Director of Nursing on 8/17/17 at 10:45 AM. She reported her expectation was for the MDS to be coded accurately.	F 278		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		8/30/17

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F 323	Continued From page 4 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review, the facility failed to provide effective supervision to prevent injury for a resident (Resident #78) who was identified as an unsafe smoker for 1 of 1 residents reviewed for smoking. Resident #78 dropped a cigarette on herself while smoking causing second degree burns to her upper and lower left thigh. The findings included: Resident #78 was admitted to the facility on 9/4/12 with diagnoses that included ataxia (the loss of full control of bodily movements), muscle weakness, and bipolar disorder.	F 323	Past noncompliance: no plan of correction required.	

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The plan of care dated 3/20/17 indicated Resident #78 required supervision for safe smoking. The interventions in place included staff supervision of Resident #78 in the designated smoking area.

The quarterly Minimum Data Set (MDS) assessment dated 3/18/17 indicated Resident #78's cognition was moderately impaired. She was assessed with no behaviors and no rejection of care. Resident #78 required the extensive assistance of one staff for bed mobility, transfers, locomotion on and off the unit, dressing, and personal hygiene. She was assessed as not steady on her feet and was only able to stabilize with staff assistance. Resident #78 had impairment on one side of the lower extremity and utilized a wheelchair.

A safe smoking assessment dated 3/20/17 required an observation of Resident #78 smoking to determine if she was able to smoke safely. The requirements for safe smoking included, in part, "Does not allow ashes or lit material to fall while smoking, inhaling, or holding smoking item ...does not endanger self or others while smoking ...does not burn furniture, clothing, skin, self, or others." Resident #78 was assessed as unsafe for independent smoking.

An incident report completed by Nurse #1 dated 5/8/17 indicated Resident #78 obtained a burn caused by direct heat exposure at 11:00 AM. The narrative of the incident and description of injuries read, "Resident [#78] in smoking area for scheduled smoke time supervised. Apron on resident at the time of smoking per Assistant Director of Nursing (ADON) and the Director of Nursing (DON). When Resident [#78] return to

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unit, [Nurse #1] noted burn hole to towel resting in resident lap. Removed towel and skin assessment revealed blistered area to upper left thigh. Burn to left upper thigh/blister 2.5 centimeters (cm) by 3.0 cm." Immediate actions included vital signs, a full skin assessment, pain medication, and notification of the physician with treatment orders provided to Resident #78.

A nursing note dated 5/8/17 at 5:25 PM written by Nurse #1 indicated she observed Resident #78 with a burned hole on a towel that was in her lap when she returned from a smoking break. Nurse #1 completed a skin assessment and noted a blistered area to Resident #78's left upper thigh. The area surrounding the blister was noted to be reddened. Resident #78 reported her pain level as a 4 out of 10. Scheduled pain medication was provided. The Unit Manager, the Director of Nursing, and Administrator were notified. The physician was notified and treatment orders were provided to Resident #78. The Responsible Party of Resident #78 was notified.

A physician's order dated 5/8/17 indicated Silver sulfadiazine 1 percent cream (an antibiotic cream used on the skin to treat second and third degree burns) to be applied to burn area on left upper thigh of Resident #78. The burn area was to be covered with non-adherent dressing twice daily until healed. A review of the Treatment Administration Record indicated Resident #78 received treatment as ordered by the physician.

An incident report follow up dated 5/11/17 indicated Resident #78 denied pain or discomfort post incident. A Plan of Correction (POC) was implemented and continued. The treatment for Resident #78 was ongoing and was to be

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continued until completely healed.

A physician's order dated 5/30/17 indicated a consultation with the wound doctor for Resident #78.

The facility wound assessment dated 5/30/17 indicated Resident #78 had a burn to the left front lateral thigh first identified on 5/8/17 caused by an accident/other trauma. The assessment indicated the Wound Care Physician (WCP) was consulted due to poor healing of the burn.

The WCP's initial evaluation dated 5/30/17 indicated Resident #78 was referred for evaluation of a burn wound of the left upper thigh of at least 21 stays in duration. There was no indication of pain associated with the condition. Resident #78 was noted to have dropped a cigarette on herself that ignited her clothing. Two wound sites were identified:
- Site 1: Burn wound of the left upper thigh (wound size 0.9 cm length, 1.1 cm width, and 0.10 cm depth)
- Site 2: Burn wound of the left lower thigh (wound size 4.5 cm length, 5.0 cm width, and 0.10 cm depth)

The medical record indicated Resident #78 was seen by the WCP for continued evaluation of her burn wounds on 6/5/17, 6/13/17, 6/20/17, 6/27/17, 7/3/17, 7/11/17, 7/18/17 and 7/25/17. Resident #78 was assessed with no signs or symptoms of pain associated with the burn wounds on all WCP evaluations. Both wound sites were noted as improved on each subsequent evaluation. Resident #78's burn wound to the left upper thigh was assessed as resolved on 6/27/17 (duration of greater than 46 days) and the burn wound to the

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left lower thigh (duration of greater than 72 days) was assessed as resolved on 7/25/17.

An interview was conducted with Resident #78 on 8/15/17 at 1:50 PM. Resident #78 confirmed she was a smoker, she required supervision while smoking, and was to wear a smoking apron for safety during the act of smoking. She verified she had been burned on the thigh by a cigarette, but she was unable to provide any additional information on the incident due to cognitive impairments.

An interview was conducted with Nurse #1 on 8/15/17 at 1:55 PM. She verified she had completed the incident report dated 5/8/17 for Resident #78. She reported Resident #78 had returned to the unit following the completion of her supervised smoking on 5/8/17. She explained that Resident #78 often kept a towel on her lap to protect her clothing from food and other items as she tended to have spastic and uncontrolled movements. Nurse #1 stated she noticed a burn hole on the towel that was in Resident #78 ' s lap which led to the identification of the burn to Resident #78's left thigh. She stated the Administrator and DON were on the unit at that time and were notified of the injury. Nurse #1 indicated the Physician Assistant (PA) was also on site at the facility and she came to the unit to assess Resident #78 and she provided orders for treatment.

An interview was conducted with the Administrator on 8/15/17 at 2:10 PM. She indicated she was familiar with Resident #78 and was aware of the incident on 5/8/17. She stated the DON was supervising the smoking area at the time of 5/8/17 incident with Resident #78. She

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reported the investigation into the incident revealed Resident #78 had her smoking apron on, but it was tied around her waist. She indicated Resident #78 was in a wheelchair and the cigarette had fallen in the gap between the arm of the wheelchair and Resident #78's leg. Her leg was not fully protected by the smoking apron. The Administrator reported a POC was immediately implemented. She stated this POC included changing the placement of the smoking aprons for residents in wheelchairs and/or seated in chairs. She indicated instead of tying the aprons around the waist of the resident, the apron was to be tied around the arms of the wheelchair/chair to protect their entire lap and leg area. She reported the POC additionally included re-education of all facility staff on safe smoking practices as well as smoking assessments and ongoing audits.

An interview was conducted with the DON on 8/15/17 at 2:29 PM. She confirmed she was supervising the smoking area during the incident on 5/8/17 with Resident #78. She explained that on the date of the incident, smoking time was initially supervised by Nursing Assistant (NA) #1. NA #1 reportedly had an emergency and she (the DON) was called to the smoking area to replace NA #1 and to supervise the remainder of the smoking time. She reported the smoking area was supervised by at least one staff member throughout this smoking time. The DON verified Resident #78 had her smoking apron on, but it was tied around her waist which allowed for a gap between the arm of the wheelchair and Resident #78's legs. She explained that Resident #78's hands tended to tremble which caused her difficulty extinguishing her cigarette. She reported Resident #78 was instructed by staff to

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drop her cigarette on the ground and the staff then extinguished and disposed of the cigarette. She explained when she replaced NA #1 as the smoking supervisor, Resident #78 had no cigarette in her hand. She stated she lit a cigarette and gave it to Resident #78. She reported when the smoking time had been completed she removed Resident #78 ' s smoking apron and accompanied her back to her unit. She stated she assisted Resident #78 with repositioning in her wheelchair when she noticed a brown mark on the towel in the resident's lap. She revealed when the towel was removed from Resident #78, it was apparent the cigarette the burned through the towel, through her pants, and burned the top of her leg. She stated Resident #78 had not said anything about the burn or about any pain. The DON stated Resident #78 was immediately assessed by herself, Nurse #1 and the PA. She revealed the injury was assessed as a second degree burn. She reported pain medication was administered and new treatment orders were received from the PA.

This interview with the DON continued. She stated an investigation into the incident began that day (5/8/17) as well as the initiation of a POC. The DON explained that Resident #78 had a towel that was partially rolled up between the arm of the wheelchair and her leg. The smoking apron was tied around Resident #78 ' s waist. She stated Resident #78 had dropped her cigarette in the gap between the arm of the wheelchair and her leg, which was not fully covered by the smoking apron. The DON stated she believed Resident #78 had meant to drop her cigarette on the ground, but had mistakenly dropped it on herself. She indicated Resident #78 was unable to explain what had happened.

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The DON reported Resident #78's burn to the left thigh was treated as ordered by the physician until the burn was fully healed. She confirmed the WCP was consulted on 5/30/17 for evaluation of the burn wound due to poor healing. The DON verified the WCP had evaluated Resident #78's burn wound as two separate wound sites to the left thigh. She stated both of these wound sites were identified on 5/8/17, they were assessed as one wound site, and had had been treated as ordered with wound care since the time of the incident.

NA #1 was unavailable for interview.

An observation was conducted on 8/16/17 at 10:08 AM of Resident #78 in the designated smoking area at the designated smoking time with staff supervision. Resident #78's smoking apron was tied around the chair and there were no concerns observed with the safety of her smoking.

The corrective action for past non-compliance dated 5/8/17 was as follows:

1. Resident #78 was given a full skin assessment from head to toe by the DON and PA on 5/8/17. Any areas of skin concern were addressed and treatment orders were obtained. Resident #78 was assessed for pain at the time of skin inspection. Resident #78 received scheduled pain medication prior to the skin inspection and had no complaint of pain at the time of the inspection. Resident #78 received another smoking assessment by the SW on 5/8/17. Resident #78 was again assessed as unsafe to smoke independently and required staff supervision when smoking. Date of completion:

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F 323	Continued From page 12 5/8/17. 2. All residents who smoke (safe and unsafe) were given a smoking assessment by the SW and the Activities Director on 5/8/17. Any resident determined to be unsafe with smoking was placed on the list for supervised smoking immediately. All smoking aprons were assessed for integrity by the DON and the Administrator on 5/8/17. An inspection of the clothing of all residents who smoke (safe and unsafe) was performed by laundry personnel on 5/8/17 and 5/9/17 to determine if residents deemed safe could possibly be unsafe at times other than when the smoking assessment was completed. No concerns were identified by this review. All residents who smoke (safe and unsafe) were given a head to toe skin assessment by the Registered Nurse Supervisor between 5/8/17 and 5/9/17. No concerns were identified by this review. Date of completion: 5/9/17. 3. All staff (licensed and unlicensed in all departments), including the DON, were in-serviced regarding the procedure for safe smoking practices. This inservice included, but was not limited to, times for supervised smoking, duties of supervising staff, signs to recognize safe smokers, and the proper technique for placing a smoking apron on residents. These in-services were provided by the Assistant Director of Nursing on 5/8/17 through 5/10/17. The Environmental Services Director (ESD) will wash and inspect all smoking aprons weekly for integrity. If an apron is determined to be unsafe/worn/damaged the ESD is to dispose of the apron and order a new one if needed. All residents that smoke will be evaluated by a smoking assessment at least quarterly or at the	F 323		

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	345534	A. BUILDING _____ B. WING _____	08/17/2017

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F 323	Continued From page 13	F 323		

time of their MDS assessment. These assessments will be completed by the SW. All newly admitted or readmitted residents will receive a smoking assessment upon admission by the admitting nurse. All residents determined to be unsafe to smoke independently will have their smoking materials (lighters, cigarettes, etc.) in the facility container which is only accessible by staff. The smoking materials will be made available to residents under supervision only. Date of completion: 5/10/17.

4. To maintain quality assurance, a member of the management team will provide impromptu inspection of the smoking area at least once daily for one week, weekly for one month, and monthly for three months. Findings of these inspections will be presented in the monthly Quality Assurance and Improvement Meeting for a minimum of three consecutive months.

As part of the validation process on 8/16/17 and 8/17/17, the plan of correction was verified. The re-education of staff (in-service sign in sheets dated 5/8/17 through 5/10/17) was reviewed. Interviews with staff (licensed and unlicensed) revealed they were retrained on safe smoking practices following the 5/8/17 incident with Resident #78. Observations were conducted of the smoking area to ensure residents were smoking safely with effective supervision. Resident #78 was observed smoking safely with no identified concerns. A review of the monitoring tools revealed the facility completed all audits as noted in their POC. A review of the audits revealed the apron inspection audits had been completed weekly beginning on 5/8/17 and were ongoing. A review of the smoking area audits revealed it had been completed once a day

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F 323	Continued From page 14 from 5/8/17 through 5/16/17, once a week from 5/17/17 through 6/19/17, and once a month from 7/4/17 through present (most recent review on 8/14/17). No concerns were identified during the audits. The final correction date was 5/10/17.	F 323		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be	F 431		9/1/17

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F 431	Continued From page 15 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to date multi dose medications and supplements and to discard expired and single use medication from 2 of 4 medication carts observed (200 and 300 hall medication carts). Findings included: 1. On 8/17/17 at 9:35 AM, the medication cart on 300 hall was observed. There was a bottle of Normal Saline 100 milliliter (ml) observed that was opened and undated. The bottle read "single patient use". There was also a bottle of Prostat (protein supplement) observed that was opened and undated. The manufacturer's instruction on the bottle of the Prostat read to discard 3 months	F 431	F431 – DRUG RECORDS, LABEL/STORE DRUGS&BIOLOGICALS Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. All medications found to be unlabeled or expired including; normal saline, Prostat,	

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F 431	Continued From page 16 after opening. On 8/17/17 at 9:38 AM, Nurse #2 was interviewed. She stated that the Normal Saline should have been discarded after use. Nurse #2 was observed to discard the bottle of Normal Saline. Nurse #2 further stated that the Prostat should have been dated when opened and she acknowledged that the bottle was not dated when opened. She indicated that nurses were responsible for checking the medication carts every day for expired and undated medications. On 8/17/17 at 10:40 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the nurses to discard single use medication after use. The DON also indicated that she expected the nurses to date Prostat when opened and to discard it 3 months after opening per the manufacturer's instruction. 2. On 8/17/17 at 10:25 AM, the 200 hall medication cart was observed. There was a used Advair diskus (used to treat Asthma and Chronic Obstructive Pulmonary Disease) observed that was dated 7/6/17. There were also two (2) used Advair diskus inhalers observed that were undated. The manufacturer ' s instruction written on the box was to discard the Advair 1 month after the foil pouch was opened. On 8/17/17 at 10:30 AM, Nurse #3 was interviewed. She acknowledged that the Advair diskus that was dated 7/6/17 was already expired and she stated that she would discard it. She also stated that the 2 Advair diskus inhalers should have been dated when the foil pouch was opened but they were not dated. Nurse #3 indicated that Advair diskus was good for 30 days	F 431	and Advair Diskus were disposed of on August 17, 2017. On August 18, 2017 the Director of Nursing and members of nurse management completed an audit of all medication storage areas including nurse carts, medication storage rooms, and medication refrigerators to ensure all medications were properly labeled and stored within regulatory guidelines. All licensed nursing staff was in-serviced by the Staff Development Coordinator between the dates of August 18, 2017 and September 1, 2017 regarding proper storage of drugs including but not limited to monitoring expiration dates and labeling and dating opened packaging. To ensure quality assurance, nurse administration will audit medication storage areas including; medication carts, medication storage rooms, and medication refrigerators, to ensure proper storage, labeling, and dating of medications. These audits will be completed Monday thru Friday for two weeks, twice weekly for two additional weeks, and weekly for two months. Results of these audits will be presented in the QAPI Meeting for a minimum of three consecutive meetings.	

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F 431	Continued From page 17 after opening. On 8/17/17 at 10:40 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the nurses to date the Advair when opened and to discard it 30 days after opening per the manufacturer's instruction.	F 431		